

This form is due back on or before AUGUST 1st

School of St. Ann
EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT 2007-2008
 (To be completed by parent-One per family)

Family Name

Student's first & last name:

1. _____/Grade: _____, 4. _____/Grade: _____
 2. _____/Grade: _____, 5. _____/Grade: _____
 3.: _____/Grade: _____, 6. _____/Grade: _____

Students live with : Both Parents Mother Father, Legal custody Mom Dad Joint

Dad: _____ Address: _____ Telephone() _____
 Place of Employment: _____ Occupation: _____
 Work # () _____ Cell Phone #: () _____
 Beeper #: () _____ E-Mail: _____

Mom: _____ Address: _____ Telephone:() _____
 Place of Employment: _____ Occupation: _____
 Work #: () _____ Cell Phone #: () _____
 Beeper #: () _____ E-Mail: _____

Step-Dad: _____ Address: _____ Telephone:() _____
 Place of Employment: _____ Occupation: _____
 Work #: () _____ Cell Phone #: () _____
 Beeper #: () _____ E-Mail: _____

Step-Mom: _____ Address: _____ Telephone() _____
 Place of Employment: _____ Occupation: _____
 Work # () _____ Cell Phone #:() _____
 Beeper :() _____ E-Mail: _____

IN CASE OF AN EMERGENCY AND A PARENT CANNOT BE REACHED, THE FOLLOWING LOCAL PEOPLE CAN BE CONTACTED TO RESPOND IN THE PARENT'S ABSENCE.

Name	Phone	Relationship
1.	H: _____ W: _____ C: _____	
2.	H: _____ W: _____ C: _____	
3.	H: _____ W: _____ C: _____	


 Name of Physician and Phone # _____

 Name of Dentist and Phone # _____

 Name of Orthodontist and Phone # _____

CONSENT TO ADMINISTER MEDICATION

School personnel must have parental consent for all "over the counter" medications, and a physicians orders for all prescription medications. All medications MUST be brought in their original container. All medications will be maintained in the nurses office and administered according to label instructions and at the discretion of the school nurse. If it is necessary for the student to retain possession of medications (i.e. inhalers), this must be discussed with the school nurse, requested in writing via this form and approved by your child's physician.

 I hereby give permission for _____ to be administered the following:

Name of student(s)

Non-Prescription: (Check all that apply)

- _____ Acetaminophen (Tylenol) (For headaches, tooth pain or sprains)
- _____ Ibuprofen (Advil/Motrin) (For headaches, tooth pain or sprains)
- _____ Chewable Antacids (TUMS) (For stomach aches)
- _____ Over the counter medications (such as, cold or allergy medications, Calamine, Neosporin, etc.).
- _____ **I DO NOT WANT MY CHILD TAKING ANY MEDICATIONS AT SCHOOL.**

Is my child(ren) allergic to any medications? Yes No, If so, _____ please list them: _____

I further understand that any school employee who administers any prescription or "over the counter" drug in accordance with written instructions from a physician, dentist, or parent shall **not** be liable for damages as a result of an adverse drug reaction suffered by a student because of administering such a drug. I hereby authorize the school nurse or person designated to administer medication in her absence, to administer the following medications (OTC) and or prescriptions. All medications will be maintained in the nurses office and dispensed according to label instructions and at the discretion of the school nurse.

If your child(ren) should become seriously ill or injured at school and you or your physician cannot be reached within a reasonable length of time, may a staff member of St. Ann's Catholic School have permission to take appropriate action to see that your child gets emergency hospital care via ambulance? YES NO

You have permission to transport my child(ren) by bus or other means to take part in field trips, concerts or any event sponsored by the school. YES NO

I, the undersigned, do hereby authorizer officials of St. Ann School to contact directly the persons named in this sheet, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the said child(ren).

In the event physicians, other persons named in this sheet, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in this judgement, for the health of the aforesaid child(ren).

I will not hold the school district financially responsible for the emergency care and or transportation for the said child(ren).

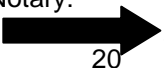
Statement of Consent:

In order to better serve the health needs of my child, I hereby give permission for the transfer of health history and screening records to the teachers, staff and other health professionals that deal with my child(ren) at St. Ann School. I acknowledge this will keep all staff members informed of any changes in my child's health. I have been given a copy of my FERPA (rights to privacy) that is in the school calendar for this school year 2007-08



Signature of Parent or Guardian

Notary:



20__.

Parent or Guardian please print your name here

My commission expires on:

Notary